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EDITOR'S PAGE

Do We Practice Geriatric Cardiology?

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An immediate reflex response to the above question would be yes. Our patients with heart disease are getting progressively older as we experience a "graying" of the population. A good example of this is the population with heart failure. Even though the death rate from heart disease is declining, the incidence and prevalence of heart failure continue to rise, especially in the elderly. In 1990, individuals ≥65 years of age comprised 12% of the U.S. population. Yet, they accounted for 59% of hospital admissions for acute myocardial infarction (MI), 64% of admissions for arrhythmias and 80% of admissions for heart failure. Individuals ≥75 years old accounted for 32% of admissions for acute MI, 38% of admissions for arrhythmias and 54% of admissions for heart failure (National Hospital Discharge Survey, 1990). In light of these and similar statistics, it seems self-evident that we are practicing geriatric cardiology. Or are we?

I recently attended a conference in Banff entitled, "Integrating Geriatrics Into Cardiology." In recognizing the aging of America, the purpose of the conference was to enrich the training of medical subspecialists in gerontologic and geriatric aspects of their disciplines. Several geriatrician speakers pointed out the differences between the "old" patients that we see and the frail elderly patient population they follow up. We tend to see "old" patients with heart problems who are still quite functional otherwise. They live at home, take care of themselves and in some instances may lead very active and productive lives. They generally follow directions, take their medicines and have a minimum of other concomitant problems. Usually, we focus on therapy to prolong their life, using state of the art therapy.

On the other hand, geriatricians tend to follow up frail, elderly patients who may be in nursing homes or similar environments. They may be demented, hard of hearing, unable to fully care for themselves, incontinent and forgetful and have a multitude of concomitant medical problems. The fact that they have heart disease is almost incidental to their other problems. They require a multidisciplinary approach to care for the complexity of their medical problems. The focus of therapy is not to prolong life but to maintain a reasonable quality of life through integrated systems of care involving multiple disciplines.

Obviously, there is a continuum between the two groups of patients characterized here, but it is clear that cardiologists could learn a lot from geriatricians about the care of the frail, elderly patients described above. One way to do this is for cardiology training program directors to incorporate some aspects of geriatric training in their programs. This might best be taught by geriatricians and could include such elements as:

- Geriatric assessment (both cognitive and functional), activities of daily living, appropriate use of the history, physical and mental examinations and the laboratory.
- Coordination of actions of multiple health professionals, including physicians, nurses, psychiatrists, social workers, dietitians and rehabilitation experts.
- Psychosocial aspects of aging, including housing, depression, bereavement and anxiety.
- Ethical and legal issues, including limitation of treatment, competency, guardianship, right to refuse treatment, advance directives, wills and durable power of attorney for medical affairs.
- Economic aspects of supporting services, including Title III of the Older Americans Act, Medicare, Medicaid and cost containment.
- Pharmacologic problems associated with aging, including changes in pharmacokinetics and pharmacodynamics, drug interactions, overmedication, polypharmacy and compliance issues.
- Preventive aspects, including management of risk factors, exercise, nutrition, immunization and use of community resources.

This list is not intended to be complete but illustrates some of the topics that might enhance the training of cardiologists

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who will increasingly be caring for progressively older patients. The numbers speak for themselves. Those >65 years old have more than four times the number of physician visits and four to five times the length of hospital stay as those <65 years old. In persons ≥75 years old, one of every two visits is for cardiovascular disease. The cost for the care of older persons in the United States is >$90 billion.

I concur with the conclusions of the Banff conference that cardiology needs to take up this challenge. Are we currently practicing geriatric cardiology? Yes and no. Yes because we care for this age group, and no because we are less well prepared to fully coordinate the care of the frail elderly. We need to learn from the geriatricians those elements of care that will fully qualify us to practice geriatric cardiology.